



UBC CENTRE FOR
HEALTH SERVICES AND
POLICY RESEARCH

Value in Canadian Healthcare Evolution or Revolution?

Conference Summary

June 2019

CHSPR 2019 HEALTH POLICY
CONFERENCE

Jason M. Sutherland PhD

Kate Redfern MSc

Dawn Mooney MPH



THE UNIVERSITY OF BRITISH COLUMBIA

Value in Canadian Healthcare: Evolution or Revolution? Conference Summary
was produced by:

Centre for Health Services and Policy Research
University of British Columbia
201-2206 East Mall
Vancouver, BC V6T 1Z3
Phone: 604-822-4969
Email: chspr.reception@ubc.ca

You can download this publication from www.chspr.ubc.ca

Contents

- 2 About CHSPR and CHSPR's Health Policy Conferences
- 3 About the Conference: Value in Healthcare: Evolution or Revolution?
- 4 Opening Keynote: What is Value in Healthcare?
Dr. Ellen Nolte, Professor, London School of Hygiene and Tropical Medicine
- 6 Panel I: A System Perspective on Achieving Higher Value
Ms. Mary Ackenhusen, President and CEO, Vancouver Coastal Health Authority
Dr. Paul Woods, President and CEO, London Health Sciences Centre, Ontario
- 8 Panel II: Modernizing for Improving Value—Measuring Health, Cost and Value
Dr. Theodore Ganiats, Professor, University of California San Diego
Mr. Patrick Power, Managing Director, PowerHealth Solutions (Australia)
Mr. Fred Horne, Fred Horne Associates
- 11 Keynote: Comparative Policy Analyses for Improving Value—A View from the USA
Dr. David Radley, Senior Scientist, Commonwealth Fund
- 12 Parallel Session I: Focus on Primary Care: Innovations in Care Delivery
Dr. Kristen Brown, President and Chief Medical Officer, Mercy Health Physician Partners
Dr. Ruth Lavergne, Assistant Professor, Simon Fraser University
Dr. Kamila Premji, Family Physician, Western University
Dr. Dan Niven, Assistant Professor, University of Calgary
- 14 Parallel Session II: Technology and Emerging Opportunities to Improve Value
Dr. Kerry Kuluski, Assistant Professor, University of Toronto
Dr. Jennifer Zelter, President and CEO, Canadian Foundation for Healthcare Improvement
Mr. Chad Leaver, Director of Applied Research, Canada Health Infoway
Dr. Michael Humer, Thoracic Surgeon, Kelowna General Hospital
- 16 Summative Reflections on the Conference's First Day
Dr. Ruth Lavergne, Assistant Professor, Simon Fraser University
Dr. Kerry Kuluski, Assistant Professor, University of Toronto
- 17 Panel III: Reforming the Delivery System with Integrated Models of Care
Dr. Walter Wodchis, Professor, University of Toronto
Ms. Alexandra Clyde, Vice President, Global Health Policy, Reimbursement, and Health Economics, Medtronic Inc.
Dr. Jeroen Struijs, Senior Researcher, National Institute of Public Health and Environment (Netherlands)
- 20 Panel IV: Moving the Agenda of Reducing Low-value Care Forward
Dr. Fiona Clement, Associate Professor, University of Calgary
Dr. Noah Ivers, Assistant Professor, University of Toronto and Women's College Hospital
- 22 Closing Keynote: The Value of Health Policy
Dr. P.-G. Forest, Professor, University of Calgary

About CHSPR

The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based in the School of Population and Public Health at the University of British Columbia (BC). Our mission is to stimulate scientific enquiry into health system performance, equity, and sustainability.

Our faculty are among Canada's leading experts in primary health care, health care funding and financing, variations in health services utilization, health human resources, and pharmaceutical policy. We promote inter-disciplinarity in our research, training, and knowledge translation activities because contemporary problems in health care systems transcend traditional academic boundaries.

We are active participants in various policy-making forums and are regularly called upon to provide policy advice in BC, other provinces, and abroad.

We receive core funding from the University of BC. Our research is primarily funded through competitive, peer-reviewed grants obtained from Canadian and international funding agencies.

For more information about CHSPR, please visit www.chspr.ubc.ca.

CHSPR's Health Policy Conferences

CHSPR's annual health policy conference creates an opportunity for those interested in health policy issues and challenges to hear about emerging research and engage in interactive dialogue with experts in thematic areas. The conference draws leaders and researchers from universities, governments, industry, health authorities, and health and patient organizations from BC, the rest of Canada, and beyond. For summaries of past conferences, please visit www.chspr.ubc.ca/conference/past-conferences.



About the Conference

Value in Canadian Healthcare: Evolution or Revolution?

On March 7-8, 2019, over 220 health policy experts, health system managers, researchers, students and members of the public from across Canada gathered in Vancouver for CHSPR's 31st annual health policy conference.

The theme was to present policy options for, and debate, improving the value from healthcare in Canada. The concept of value, and value-based healthcare, is increasingly appearing in the popular media, policy documents and health services literature—often without definition or a common understanding of what value in healthcare looks like. The conference aimed to define value in healthcare, debate alternative frameworks for measuring value, and propose policy options for improving value. The conference drew from international experts in health systems research and included national, provincial and local health system managers, policy researchers, clinician scientists and patients. Participants were exposed to discussions regarding structural barriers, implementation challenges, patient experiences and policy goals regarding measuring and improving value from healthcare.

This document presents a summary of the presentations, discussions, and lessons learned, drawing from all experts and audio transcripts. Following the flow of the conference, the aim of the document is to present the current policy thinking on the topic of improving value from healthcare in Canada, synthesizing expert's reflections on the topic, and concluding with a number of summative reflections. Speaker's presentations are included as an appendix, and are available at www.chspr.ubc.ca/conference.

Supporters and Conference Organization

This conference would not have been possible without the financial support of generous supporters, including the BC Academic Health Sciences Network, the BC Ministry of Health, the Canadian Foundation for Healthcare Improvement, the Canadian Institute for Health Information, the Michael Smith Foundation for Health Research, the BC Patient Safety & Quality Council, the Institute of Health Economics, the BC Primary Health Care Research Network, the UBC School of Population and Public Health, and the Canadian Institutes of Health Research. This report would not have been possible without the support of Health Canada.

The conference program and planning committees were chaired by Dr. Jason Sutherland of CHSPR. The conference program committee included a number of prominent health system and health policy leaders. The conference planning committee was led by Ms. Dawn Mooney and Ms. Joyce Huang of CHSPR. Conference support was provided by Face2Face Events Management.



Opening Keynote: What is Value in Healthcare?

Speaker

Dr. Ellen Nolte, Professor, London School of Hygiene and Tropical Medicine

Dr. Nolte presented the current school of thought regarding value from healthcare from a European perspective by summarizing countries' principles regarding their healthcare systems. Through her recent leadership role with the European Observatory on Health Systems, Dr. Nolte provided the basis for evaluating 'value' from healthcare by noting the European Union's perspective on value from healthcare has been founded on social equality and solidarity. The reference point for the European Union's focus on social equality and solidarity as the principles for value from healthcare was the 2006 European Council on Common Values and Principles and the 2008 Tallinn Charter, the latter which focused on health and health systems.

Dr. Nolte described that the financial crisis of 2008 strained the European Union countries' principles of social equality and solidarity, as countries changed their health insurance benefit packages—mostly reducing insured benefits. These changes in countries' health benefit programs disproportionately affected countries most affected by the financial crisis. This change increased European Union's populations' disparities in access to health services, drugs and social services known to impact health (i.e., food security.) The impact of these changes is still reverberating through European Union countries' health systems, as Dr. Nolte noted that there are significant differences in value for money among countries.

Focusing on the topic of primary care, Dr. Nolte described that countries of the European Union have had varying levels of success in developing effective, accessible and resilient primary care systems. Citing the evidence that countries with robust primary care systems tend to have better population health, Dr. Nolte described that many European Union countries struggle with coordination in care between providers and sectors. Among European Union countries, Dr. Nolte described that Sweden and the Netherlands have appeared to have had the most success investing in and developing robust primary care systems. Dr. Nolte highlighted the efforts of England's National Health Service (NHS) to accelerate its primary care reform efforts through its NHS Long Term Plan, though the effects are still unknown.

Dr. Nolte highlighted that value is intertwined with issues associated with the healthcare workforce, articulating that the healthcare workforce is an integral component of increasing value from healthcare through its size, skill mix and robustness to change. First, Dr. Nolte described that the healthcare workforce of the future should have an expanded set of skills, move between sectors as needed, and have skills for communicating across professional boundaries (scope of practice). She described literature reporting significant challenges associated with making changes in the healthcare workforce, including shifting from a paternalistic perspective towards deliberative care. Barriers to change included fearing change in roles or responsibilities, and lack of resources to care for a population of people, and funding programs oriented towards healthcare sectors or settings. Dr. Nolte described potential solutions to these barriers, including strategies for overcoming encroachment between professional roles, funding health services differently and education that includes inter-professional communication.

Dr. Nolte finishing her plenary address with a number of considerations for healthcare policymakers to address. These included measuring what matters to patients, more careful consideration of funding/incentive programs for healthcare providers, adequate resourcing for providers to ensure more ‘time’ with patients (noting that general practitioner consults are six minutes in England but 20 minutes in Sweden,) and increasing the prominence of the public in health system decision-making.

...a number of considerations for healthcare policymakers to address, includ[ing] measuring what matters to patients, more careful consideration of funding/incentive programs for healthcare providers, adequate resourcing for providers to ensure more ‘time’ with patients, and increasing the prominence of the public in health system decision-making.

Panel I: A System Perspective on Achieving Higher Value

Speakers

Ms. Mary Ackenhusen, President and CEO, Vancouver Coastal Health Authority

Dr. Paul Woods, President and CEO, London Health Sciences Centre, Ontario

Dr. Ackenhusen led the panel by describing that managing BC's most populous health authority is a balance of financial and human resources. She described that the health authority experiences significant fragmentation between providers and settings, and explained that general practitioners are independent actors and not bound by the health authorities' strategic directions. Ms. Ackenhusen described that the health authority's significant problems included over- and under-use of health services attributable to fragmentation, isolation of healthcare from social care, and gaps in care among the frail elderly.

Ms. Ackenhusen followed by describing the organization's initiatives to address the problems. Among the innovations is the embrace of technology, citing examples of the Marshfield Health System and its hospital at home programs and Mercy Virtual Care Center, a virtual hospital that uses telemedicine and video technologies to remotely manage patients with nursing care.

Ms. Ackenhusen concluded her presentation with an enumeration of barriers that are impeding progress in improving value for the health authority. The most significant items included resistance to change among providers or managers, and intolerance of failure. She then described programs underway within Vancouver Coastal Health Authority to address the items, including changing the workplace culture to make staff feel valued, improving the work experience of staff, and encouraging strategic planning and brainstorming within work units.



Dr. Woods started his presentation by describing the challenges he faces running an academic hospital in Ontario: pressure for increasing volume of care and decreasing the per-case cost. He described a number of important contextual challenges he faces managing the academic medical centre, including: observing significant waste in the system, data and information are slow or often don't help with decision making, effective pilots that are inadequately resourced in order to be scaled across the system or hospital, self-interested providers, and a lack of information regarding the contextual factors of his hospital's patients (i.e., social care).

Dr. Woods strongly advocated movement towards models of integrated care and supportive funding models. He described that the most significant barrier to improving value has been strengthening and integrating primary care with secondary care provided by hospitals. Dr. Woods described the most significant barriers to improving value from his perspective included: provincial regulations that contradict one another, differences in culture between providers, large geography, a physical infrastructure that doesn't align well with the health needs of his hospital's patients, and lack of accountability between providers (most notably physicians).

Dr. Woods concluded with his vision of policies that would improve value from healthcare. These policies include multi-year funding envelopes that enhance flexibility, alignment of physician's incentives with other sectors and settings of care, and a government that had 'tighter' objectives/outcomes but permitted more flexibility regarding how provider organizations could achieve the delivery system's objectives.

...policies that would improve value from healthcare
... include multi-year funding envelopes that
enhance flexibility, alignment of physician's
incentives with other sectors and settings of care,
and a government that had 'tighter' objectives/
outcomes but permitted more flexibility regarding
how provider organizations could achieve the
delivery system's objectives.

Panel II: Modernizing for Improving Value— Measuring Health, Cost and Value

Speakers

Dr. Theodore Ganiats, Professor, University of California San Diego

Mr. Patrick Power, Managing Director, PowerHealth Solutions (Australia)

Mr. Fred Horne, Fred Horne Associates

This panel was led by Dr. Ganiats, who focused on measurement of health. Dr. Ganiats described that patient-reported outcomes are increasingly being used to measure the patient's perspective of value from health services and reflect an improved patient-centred model of care. Dr. Ganiats described that patient-reported outcomes provide a complementary perspective of the patient and disease and provide insights into what symptoms or conditions are most bothersome to patients.

Dr. Ganiats provided a number of limitations of patient-reported outcomes, including that patient-reported outcomes tend to measure what is bothering patients contemporaneously, so that the time horizon should match measurement and intervention. He also noted that patient-reported outcomes take time to develop and validate for new settings or conditions and that symptoms being measured and reported should reflect patients' care goals.

Dr. Ganiats concluded by opining that value from healthcare is care that is safe, effective and patient-centred, where the latter is measured through outcomes that matter to patients.



The next speaker was Mr. Patrick Power of PowerHealth Solutions, a vendor of software that attributes hospitals' activities with their costs to the patient episode. This process of attributing costs to patients' activities is referred to as 'patient-level costing' and is common among Ontario hospitals.

Mr. Power described that patient-level cost information is valuable to providers, health system managers and government. For providers, cost information lets providers know the consequences of their decisions on cost. For health system managers, cost information provides insights into how time and resources are being used. For the ministries of health, the cost data generated from hospitals, linked with the patients' clinical activities, provides a basis for funding hospitals on the

basis of their activities. In other words, patient-level cost information is a fundamental component of activity-based funding, since cost information integrated with clinical activity can be used to generate case mix remuneration amounts.

Mr. Power highlighted that cost information, to be most useful to hospital managers, needs to be:

1. Available quickly,
2. Physically accessible to those that need the information,
3. Easy to analyze, and
4. The methods used to generate the costs need to be transparent to all users so that users have confidence in the cost information.

Mr. Power highlighted a recent example in Quebec wherein hospital's cost information, linked with clinical activity, has shown a positive association between patients' number of contacts with their nurse and patient-reported satisfaction measures.



The panel concluded with a presentation by Mr. Fred Horne, who proposed the measurement of 'value' by tying together the concepts of 'health' described by Dr. Ganiats with the concept of 'patient cost' presented by Mr. Power. Mr. Horne noted that his comments regarding value were based on his experiences and observations as the minister of health in Alberta and his recent work with the International Consortium of Health Outcomes Measurement (ICHOM).

Mr. Horne noted a number of important limitations in the healthcare system that inhibit improving value. First, he thought that volume-based approaches to providing and funding healthcare do not provide a pathway to ensuring patients' health is improved or maintained. He singled out physician compensation as a domain that needs reform. He also considered that change in the healthcare system takes longer than a single budget cycle and governments should develop/implement plans that transcend fiscal years and election cycles. He also identified additional limitations to improving value from healthcare, in that providers have no experience with risk sharing models and have no financial flexibility to invest for the future.

Mr. Horne's proposed solutions to address the limitations were to leverage the existing healthcare ecosystem, specifically the Canadian Institute for Health Information's data collecting and reporting, the Canadian Foundation for Healthcare Improvement's experience with quality improvement, Canada Health Infoway's experience expanding interoperability between healthcare organizations and sectors, and the Canadian Agency for Drugs and Technologies in Health's experience in drug and device evaluation. His opinion was that each of these agencies should expand their activities significantly to:

1. Identify micro-systems that have been operating cost-efficiently and effectively,
2. Scale micro-systems that are working well,
3. Expand collection of patient-reported outcomes and patient-reported experience measures,
4. Expand evaluation of drugs and devices to health services,
5. Implement analytic tools for health system managers for comparative analyses, and
6. Expand digital technologies to reduce fragmentation.

Mr. Horne concluded his talk by describing that provinces need to collect and report on healthcare costs, measure outcomes that matter to patients and identify opportunities to collaborate with industry to improve value.

...provinces need to collect and report on healthcare costs, measure outcomes that matter to patients and identify opportunities to collaborate with industry to improve value.

Keynote: Comparative Policy Analyses for Improving Value—A View from the USA

Speaker

Dr. David Radley, Senior Scientist, Commonwealth Fund

Dr. Radley began by describing the contextual differences between Canada and the United States' health insurance and delivery systems. Adopting a Porter & Tiesberg value-based healthcare framework, he noted that insurers want to lower spending, increase enrollment and make a profit. At the same time, patients want high quality care that is timely, is consistent with their healthcare goals, communicated with respect, and is affordable.

Dr. Radley then focused on the need for reforming the predominant mode of payment in the United States, fee-for-service, and its role in undermining team-based care models. He highlighted that significant payment/funding reforms have been implemented over the past six years by Medicare and commercial insurers to support improved value through the use of negative financial incentives for poorer quality care. These reforms included reduced payments for excessive readmissions for chronic conditions and non-payment for related readmissions.

Dr. Radley then focused on delivery system and funding policy reforms introduced in the United States since 2010. These reforms included:

1. Population-focused models and shared savings through accountable care organizations,
2. Bundled payments for episodes of care, and
3. Merit-based payments for physicians.

Dr. Radley concluded with a number of specific examples wherein government payers and providers were innovating with payment/funding and delivery system reforms. These examples included Vermont's statewide accountable care model, Maryland's total cost of care model and Colorado's Medicaid's value-based purchasing initiatives. Dr. Radley concluded by saying that to provide improved value from healthcare, providers will have to act in patients' best interest while working to constrain spending.

Parallel Session I: Focus on Primary Care: Innovations in Care Delivery

Speakers

Dr. Kristen Brown, President and Chief Medical Officer, Mercy Health Physician Partners

Dr. Ruth Lavergne, Assistant Professor, Simon Fraser University

Dr. Kamila Premji, Family Physician, Western University

Dr. Dan Niven, Assistant Professor, University of Calgary

Dr. Brown started the panel by noting that her observations and opinions regarding improving value from healthcare were based on her experiences managing a primary care physician group that included over 200 primary care physicians in central Michigan. In her experience, pay for performance models for physicians in the United States have been too complex to achieve the programs' objectives. Notably, different payers have had different achievement or threshold performance targets for the same treatment, some of which overlap, while others are not consistent. Moreover, her experience with pay for performance was that it was 'check-box' medicine rather than outcomes-based medicine.

The failings of pay for performance led her large physician group to experiment with patient-centred medical homes. In the United States, Medicare's patient-centred homes are physician-led models of care that have providers caring for patients in a geographic area, such as a community, and supported by a range of allied health providers. The experiment is ongoing in a number of communities.

The large physician group is also participating in several accountable care organizations. While in early stages, the accountable care organization experience has been associated with more paperwork, has not involved patients or their caregivers in a meaningful manner, and has not changed the accountability structure between providers. These interim experiences led her to observe that the reforms were leading to few substantial changes in delivery models or spending. Her recommendations for new policies were based on holding providers accountable for total cost and outcomes rather than volumes.



Dr. Lavergne then described a policy initiative in BC aimed at primary care whose objective was to improve coordination between providers and sectors. The policy intervention was based on participation (a new fee code), not achievement or improvement in the patients' health, nor on overall performance measures. There were no changes in utilization or spending, but there were modest changes in prescribing patterns for chronic disease management. She articulated that the policy had no clear definition of 'value' and the payment reforms may not have affected models of care or outcomes that mattered to patients.



Dr. Premji then described a number of payment reforms enacted in Ontario during the 2000s whose objectives were to improve patients' access to primary care physicians. The policies were in response to widespread dissatisfaction with being able to access primary care in a timely way or find a regular family doctor. Some evidence suggested that while the reforms did increase the number of primary care physicians, they did not improve access when measured based on same-day/next-day access. However, subsequent research found that patient-reported timeliness of access was high. Timeliness may be a more important access indicator than the specific wait time for an appointment.



Dr. Niven concluded the panel by describing that Alberta Health Services has been pursuing a policy of developing a 'learning healthcare system' in Alberta. Anchored by Strategic Clinical Networks, the four aspects of the learning healthcare system are:

1. An intervention to change practice or outcome,
2. Monitor, evaluate and sustain efforts,
3. Knowledge creation, and
4. Identification of a problem and repeat the steps.

Dr. Niven described a successful example of Alberta Health Service's learning health system in the Critical Care Strategic Clinical Network. In the critical care setting, new evidence-based models of care had been slow to be adopted and needed support. In his story of success, the important features of the learning healthcare system were: needing a clinical champion, education regarding models of care, process change, audit and feedback of performance, and thorough evaluation.

Parallel Session II: Technology and Emerging Opportunities to Improve Value

Speakers

Dr. Kerry Kuluski, Assistant Professor, University of Toronto

Dr. Jennifer Zelmer, President and CEO, Canadian Foundation for Healthcare Improvement

Mr. Chad Leaver, Director of Applied Research, Canada Health Infoway

Dr. Michael Humer, Thoracic Surgeon, Kelowna General Hospital

This panel was led by Dr. Kuluski, who said that the traditional representation of value from healthcare, outcomes, and cost are limited in that insufficient weight is given to patients' and families' experiences and to insights that occur outside the healthcare system. She noted that even patient-reported outcomes, which represent a significant improvement in understanding patient-centred outcomes, often miss problems that matter to patients and that inadequate attention is provided to patients' caregiver's experiences or concerns.

Dr. Kuluski then shared the results of her recent research that aimed to identify themes that were important to patients and/or their caregivers but are inadequately measured, including: being comfortable, having someone to count on, having a sense of what's coming, remaining independent, and feeling safe.

To address the gaps in information regarding the information asked of patients and caregivers, Dr. Kuluski offered a number of solutions: including patients' families in care planning, measuring care throughout the care journey (not just during the isolated care episode), and employing mixed quantitative and qualitative methods to understand a fuller context.



Dr. Zelmer followed by emphasizing that value-based healthcare isn't about cost reduction, rather the concept pertains to improving outcomes that are important to patients relative to costs over the full length of a patient's journey. Dr. Zelmer noted three examples of innovative approaches being used to align resources with outcomes that matter to patients, including risk/gain sharing procurement, social impact bonds and outcome-based funding.

To provide some basis for assessing readiness to move forward with value-based healthcare, Dr. Zelmer identified 12 criteria for assessing risks and opportunities of specific initiatives. The

criteria, derived based on input from Canadian early adopters, were: availability of meaningful metrics that reflect outcomes that matter to patients, access to cost and outcomes data, clarity of scope, material impact, clinical leadership, dedicated resources (e.g. financial and human resources), permeability across health system silos, supportive policy and structures, aligned payment models, capacity/skill for value-based healthcare, proven solutions, and time to achieve value.



Mr. Chad Leaver of Canada Health Infoway followed with a presentation that began by noting that Canadians increasingly seek access to their medical records and digitally enabled health services (e.g., e-visits, e-Rx review, lab test results). Mr. Leaver noted that online access may avoid travel costs, time spent travelling, caregiving costs, and work absenteeism, thus saving patients' money, and that the health system benefits by avoiding unnecessary in-person visits and other downstream impacts. Mr. Leaver then outlined a detailed economic benefits model illustrating value-based annual estimates from the patient and health system perspectives, based on current and potential adoption of digital health services in Canada. He also noted that there is little evidence regarding the impact of online healthcare interactions, and explained that there are important barriers, such as: privacy, data security, provider remuneration models and, for providers, how to optimize their practice around online services.



The final presentation was provided by Dr. Michael Humer of Kelowna General Hospital. Dr. Humer described an exemplar clinical program in thoracic surgery that has adopted a number of new virtual technologies to expand access to thoracic surgery consultation across rural and northern BC. Previously, patients in were obligated to travel to Kelowna or Vancouver. Dr. Humer described how the program has fully adopted virtual consultations and how the virtually-based activities now represent over 40% of the clinical program's activities.

...the traditional representation of value from healthcare, outcomes, and cost are limited in that insufficient weight is given to patients' and families' experiences and to insights that occur outside the healthcare system.

Summative Reflections on the Conference's First Day

Speakers

Dr. Ruth Lavergne, Assistant Professor, Simon Fraser University

Dr. Kerry Kuluski, Assistant Professor, University of Toronto

Dr. Lavergne reflected on the themes that she heard across the first day of the conference. They included a need to transition from volume based healthcare to value based healthcare. She provided two means of achieving this transition:

1. Continuous improvement activities, and
2. Cross-jurisdictional comparisons.

Dr. Kuluski provided a complementary reflection of the day's presentations, highlighting three common points:

1. Value is more than saving money,
2. There are common barriers between provinces in effort to improving value, such as funding models, and
3. There are potential solutions for measuring value, including through patient-reported outcomes and experiences, culture redesign, and community-based engagement.

There are potential solutions for measuring value, including through patient-reported outcomes and experiences, culture redesign, and community-based engagement.

Panel III: Reforming the Delivery System with Integrated Models of Care

Speakers

Dr. Walter Wodchis, Professor, University of Toronto

Ms. Alexandra Clyde, Corporate Vice President, Global Health Policy, Reimbursement, and Health Economics, Medtronic Inc. (USA)

Dr. Jeroen Struijs, Senior Researcher, National Institute of Public Health and Environment (Netherlands)

This panel's first speaker was Dr. Wodchis, who discussed the two integrated care model reforms being conducted in Ontario, the Health Links program and the bundled payments program for select conditions.

The Health Links program aims to focus on resources and patients that are 'high users' and represent significant health expenditures. In 2012, the objective of Health Links was to provide coordinated care plans across hospital, home care and physician providers to reduce avoidable hospitalizations. In 2018, the objective was revised to focus on patients with four or more chronic health conditions. Currently, over 50,000 patients meet the criteria.

The evaluation of the Health Links program was led by the University of Toronto. The utilization indicators included hospitalizations, readmissions, emergency department visits and the number of patients seen by their primary care provider within seven days of hospital discharge. Another key outcome was spending. While the evaluation demonstrated that spending decreased, the decrease was in alignment with temporal trends, indicating that the strategy might work better among subpopulations, though at this time, it is unclear which participants would benefit the most, and from which aspects of the care plan intervention they would benefit from.

Ontario has also had six hospital-based participants in a pilot of bundled payments for select conditions. Some of the conditions showed demonstrated gains in reducing spending on unnecessary/ineffective care. The Ontario Ministry of Health considers the pilot a success and is currently expanding the program to other conditions and sites.

Dr. Wodchis provided some summative reflections on his evaluations of Ontario's experiences with delivery system and funding reforms. His comments included:

1. The culture regarding privacy and access to data varied across providers,
2. Scarcity of financial resources among smaller provider participants limited their ability to participate in care redesign,
3. The reforms competed for attention with other corporate initiatives,
4. There were instances wherein the financial savings were consumed by increases in access/volume,
5. Large geographies were challenging to overcome for some provider organizations,
6. Coordinating activities between provider organizations was challenging, and
7. It was challenging to engage physicians in the chronic care bundles.

Importantly, addressing each of these challenges requires different interventions, so the solutions may be complex.



Ms. Clyde provided the perspective of device manufacturers vis-à-vis integrated delivery models. She described that, for the device manufacturer, savings over a defined period of time (such as a bundle) are shared among provider participants. The model provides a financial incentive to encourage effective use of medical devices, reduce volume of care, and reduce costliness to the payer/insurer.

For device manufacturers, integrated delivery and payment models pose immediate changes to their business model, as they have to transition from 'volume' to 'value.' For some healthcare suppliers, these changes mean that the time horizon over which gains in health are realized vis-à-vis the associated spending is critical, as reductions in overall spending must accrue to the over the defined period of time. A consequence of this effect is that 30 days bundles have been hard to realize financial savings from, whereas there have been more opportunities in longer time horizons.

To date, the results of the integrated payment models are mixed for payers and device manufacturers. Ms. Clyde highlighted that slower implementation plans are challenging to adapt to, as some regions of the country (or health conditions) continue to be remunerated using volume-based policies whereas other regions have already transitioned to value-based funding policies. Ms. Clyde opined that the slow pace of reforms was diluting the effect of value-based policies. The presentation noted that the reforms were affected by challenges associated with the size of the physician group practice, intensity of engagement with clinician-leaders and patients participating in the care process redesign.



The third speaker in the session, Dr. Struijs, characterized the Dutch healthcare system as strong in primary care, with physicians remunerated using a blended capitation amount and fee-for-service. The Dutch have been using a bundled care model for diabetes care since 2008. The bundled payment provides flexibility in which the type of provider can vary; in other words, for diabetes care, the bundled payment covers all diabetes-related care irrespective of who provides the care. The evidence from the Netherlands has shown mixed results—slight reductions in the utilization rate of health services by diabetics, cost neutral, and possible improvement in mortality statistics.

In Dr. Struijs' opinion, the enabler of the success of the bundled payment model is the Health Care Standard for diabetes care and strong support from general practitioners. The Health Care Standard outlines the basket of services that diabetics should receive to be recognized as high quality care. The basket of services, a unique feature of the Dutch bundled care model, was agreed upon by insurers, providers and patient organizations.

The Dutch bundled payment model has been expanded to other chronic health conditions, and is currently being expanded further, and Health Care Standards are being prepared/negotiated for other chronic health conditions.

Panel IV: Moving the Agenda of Reducing Low-value Care Forward

Speakers

Dr. Fiona Clement, Associate Professor, University of Calgary

Dr. Noah Ivers, Assistant Professor, University of Toronto and Women's College Hospital

Dr. Clement led this session by defining low value care and its impact on opportunity costs and misallocation of healthcare resources. She opined that the goal of priority setting and de-adoption should be to reduce low value care. She described barriers to reducing low value care, including:

1. Difficulties in engagement across multiple layers of organizations and providers,
2. Little structure or guidance for implementing policies for reducing low value care, and
3. Reducing low value care initiatives needed strong support from policymakers and senior decision makers.

Dr. Clement shared her experiences with successful initiatives for reducing low value care. The characteristics of these initiatives included:

1. A winning team with political support,
2. Defining the playing field—what are the roles and accountabilities of all affected, and
3. Describing what actions must be accomplished with a high return on investment.



Dr. Ivers followed with a presentation that led with defining high value care, consisting of cost-effectiveness, aligning organizations' and providers' strategic goals, and cost-efficiency. He described his clinical experiences, wherein the provision of low value care that is harmful to patients is not recognized by physicians as harmful.

Dr. Ivers followed with a list of barriers to reducing low value care:

1. Changing behaviors and actions is hard for organizations and providers,
2. A robust audit mechanism is needed so physicians can 'see' the impact of their actions,
3. Design of thoughtful and transparent data collection processes which leave the data (and knowledge) unassailable to negative reactions.

Dr. Ivers opined that reducing low value care will be complex, as practice guidelines are rarely effective, and cash strapped hospitals have few sources of funds to invest in new initiatives when the return on investment is unclear. Further, he described a number of factors likely to be associated with reform to the delivery system to reduce low value care, including the need for collecting qualitative information from patients and caregivers regarding their care goals vis-à-vis their experiences. This information needs to be incorporated into a learning health system cycle of continuous improvement. In addition, the ministries of health should be clear regarding their policy objectives for cost efficiency in low value care initiatives.

Closing Keynote: The Value of Health Policy

Speaker

Dr. P.-G. Forest, Professor, University of Calgary

Dr. Forest began by describing the attributes of purpose and value of health policy. For example, as health care systems and models of care are continually changing, policies associated with the new structure and processes will always be needed. Dr. Forest then described his concept of the three-body problem for health policy: the interplay between structures, agency of providers, and ideas means that there is an ongoing need for evolving health policy. Moreover, incremental changes in policy are only occurring as a result of litigation—not federal leadership.

Dr. Forest then described that improving value and policy is irrelevant if efforts don't change care processes for patients and their caregivers in a practical and meaningful manner. While there is consensus that provinces have fairly narrow basket of insured health services (i.e., dental and vision) and variable standards of care (i.e., mental health,) provinces need policies that maximize the value of their spending on health of their populations.

Dr. Forest raised the problem of poor workforce planning efforts underway in provinces regarding non-physician professions, including nurses, dentists, and long term care aides. He posited that the mismatch between the next generations of health professionals are out of touch with the demands of future health services that residents will want in the next decade.

The next issue that Dr. Forest addressed as a means to improving value was the mismatch between resources and need. First, there has been a lacking data strategy for interfacing between public and private sources of information, and the federal government's agencies have shown little leadership in setting critical standards.

He concluded with an outline of an agenda for improving the value from healthcare in Canada. Cost efficiency must be addressed and policies that encourage, and resource, innovations need to be widespread. Patients, providers and healthcare organizations have to be deeply engaged so their perspectives are embedded within new policies and initiatives. Finally, to improve value from healthcare in Canada, the issue of equity must be addressed, especially as it pertains to Indigenous health.

Advancing world-class health services and policy research and training on issues that matter to Canadians

UBC Centre for Health Services and Policy Research

The University of British Columbia

201-2206 East Mall

Vancouver, B.C. Canada V6T 1Z3

Tel: 604.822.4969

Fax: 604.822.5690

Email: chspr.reception@ubc.ca

www.chspr.ubc.ca